CROSS Region

County **R**ural **O**ffices of **S**ocial **S**ervices

FY 2018 Annual Report

Geographic Area: Clarke, Decatur, Lucas, Marion, Monroe, Ringgold, and Wayne Counties

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I want to thank the CROSS Region Governing Board Members for their contributions to the region, their tireless work and the courage to forge new paths in uncertain times.

Introduction

CROSS Region was formed under Iowa Code Chapter 28E to create a Mental Health and Disability Service Region in compliance with Iowa Code 331.390.

In compliance with IAC 441-25 the CROSS Region Management Plan includes three parts: Annual Service and Budget Plan, Annual Report and, Policies and Procedures Manual.

This report provides an analysis of data concerning services managed for the fiscal year including July 1, 2017 through June 30, 2018. The CROSS management plans and annual report are available on the CROSS Website www.crossmentalhealth.org and DHS websites http://dhs.iowa.gov. They are also available in each member county's community services office.

Fiscal Year Overview

The Annual report reflects our fourth year of regionalization. The year began with the regional board focusing on Senate File 504, passed in the 2017 Legislative session. Senate File 504 required the regions to convene Stakeholder Workgroups to create collaborative policies and processes relating to the delivery of, access to, and continuity of services and supports for individuals with mental health, disability and substance use disorder needs.

The workgroups participated in a strategic planning process focused on filling the gaps in the continuum of care for people with complex mental health, intellectual disabilities and substance use disorders by building capacity. The strategies include crisis prevention, crisis stabilization, development of provider supports and competencies for individuals with complex needs, and coordination between regions, MCOs, IHH coordinators and providers to facilitate access to services.

The regional governance board encouraged all members to levy at the regional maximum in order to meet the demands of new service development, service sustainability, and to further advance the development of collegiality required for a successful region. The goal was achieved and implemented for fiscal year 2019.

The regional governance board also recognized the need to restructure regional operations to meet the new demands and improve efficiencies. The changes implemented in FY 2019 were to develop a regional fund for the payment of all services with member county accounts remaining in place to cover salary, benefits, and office maintenance. The region workforce was also reorganized to meet region programming needs.

Individuals Served in Fiscal Year 2018:

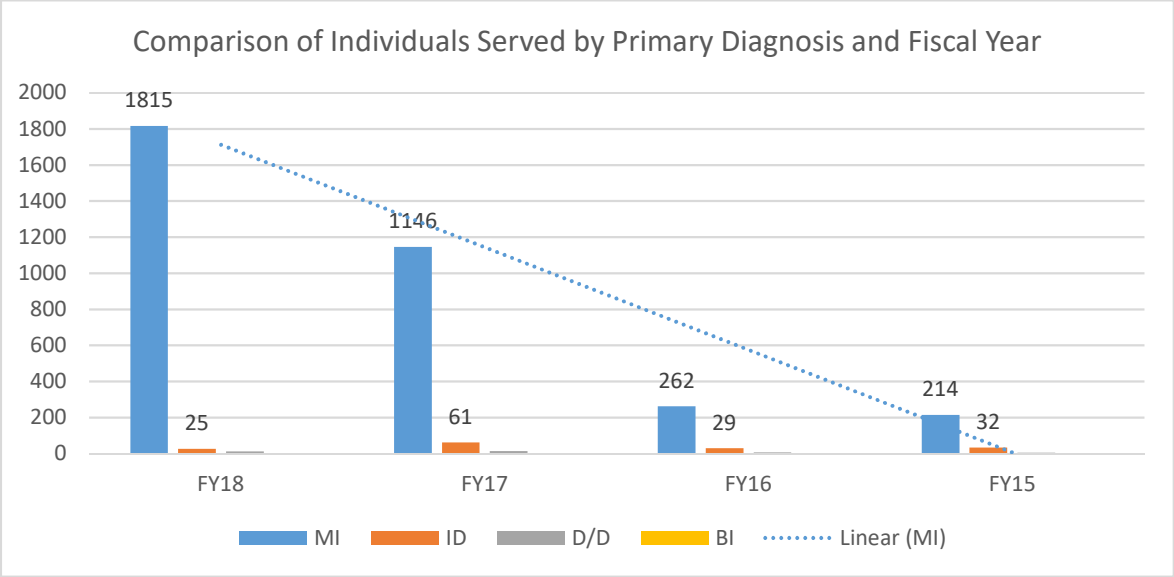
This section includes:

- the number of individuals in each diagnostic category funded for each service
- unduplicated count of individuals funded by age and diagnostic category

FY 2018 Actual GAAP	**County Rural Offices of Social Services MHDS Region**	MI (40)		ID (42)		DD (42)		BI (47)		Other		Total
Core		A	C	A	C	A	C	A	C	A	C	
	Treatment											
42305	Psychotherapeutic Treatment – Outpatient	2										2
42306	Psychotherapeutic Treatment – Medication Prescribing	3										3
71319	State MHI Inpatient – Per diem charges	7										7
73319	Other Priv./Public Hospitals – Inpatient per diem charges	3										3
	Basic Crisis Responses											
44301	Crisis Evaluation	329	114									443
	Support for Community Living											
32320	Support Services Home Health Aide	4										4
32329	Support Services – Supported Community Living	29		2		1						32
	Support for Employment											
50362	Voc./Day-Prevocational Services			1		1						2
50367	Day Habilitation	3		2		1						6
50368	Voc./Day- Individual Supported Employment					1						1
	Recovery Services											
	Service Coordination											
	Core Evidence Based Treatment											
32396	Supported Housing			1								1
42398	Assertive Community Treatment (ACT)	45										45
	Core Sub-Totals	**425**	**114**	**6**		**4**						**549**
Mandated												
46319	Iowa Medical and Classification Center (Oakdale)	7										7
74xxx	Commitment Related (except 301)	152	6	1								159
75xxx	Mental Health Advocate	86	3									89
	Mandated Sub-Totals	**245**	**9**	**1**								**255**
Core Plus												
	Comprehensive Facility and Community Based Treatment											
44313	Crisis Stabilization Residential Service (CSRS)	7										7
	Sub-Acute											
	Justice System Involved Service											
46305	Mental Health Services in Jails	100										100
	Additional Core Evidence Based Treatment											
42397	Psychotherapeutic Treatment - Psychiatric Rehabilitation	1										1
	Core Plus Sub- Totals	108										108
Other Informational Services												
Community Living Support Services												
22xxx	Services Management	211	7	5								223
23376	Crisis Care Coordination – Coordination Services	329	113									442
31xxx	Transportation	31	2	3		6						42
33340	Basic Needs- Rent Payments	3										3
33345	Basic Needs – Ongoing Rent Subsidy	52										52
33399	Basic Needs – Other	3										3
41306	Physiological Treatment – Prescription Med. / Vaccines	7										7
42399	Psychotherapeutic Treatment – Other	94	22									116
63329	Comm. Based Settings (1-5) – Supported Community Liv.	1	1									2
63xxx	RCF 1-5 beds	1										1
	Community Living Support Services Sub-Totals	732	145	8		6						891
Congregate Services												
50360	Voc. / Day – Sheltered Workshop Services	7		8		2						17
64329	Comm. Based Settings (6+ Beds)- Supported Comm. Liv.			1								1
64xxx	RCF – 6 and over beds	30		1								31
	Congregate Service Sub- Totals	37		10		2						49
Region Totals		**1547**	**268**	**25**		**12**						**1852**

The region has seen considerable growth in individuals served, especially individuals with mental illness. This is due to the creation of crisis services and services for individuals with a chronic mental illness diagnosis such as the Assertive Community Treatment program which has seen continual growth since it began in FY2017.

The graph below illustrates the growth in service usage by diagnostic type for fiscal years 2015 through 2018.



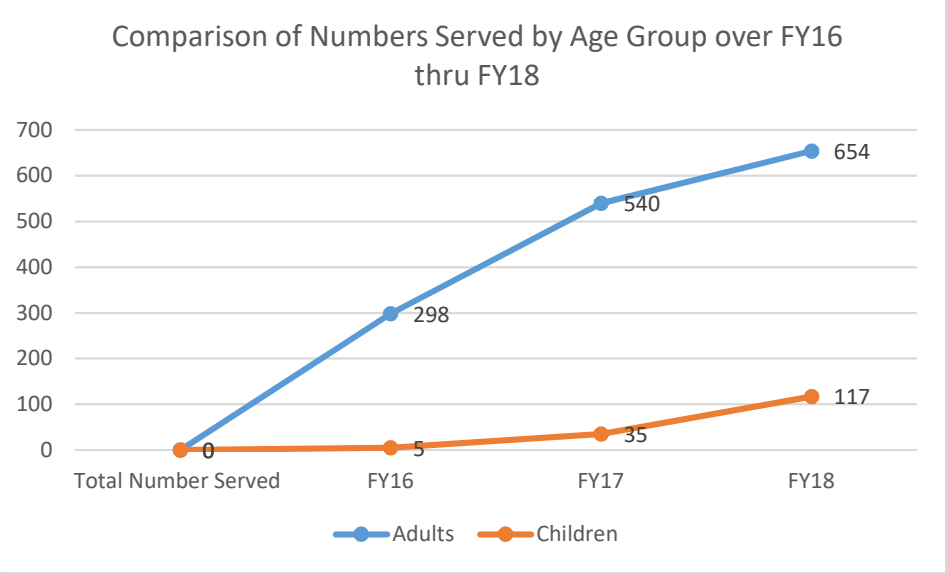
Unduplicated Count of Adults and Children by Primary Diagnosis

The chart below shows the unduplicated count of individuals funded by age group and diagnosis

Disability Group	Diagnostic Code	Children	Adult	Unduplicated Total
Mental Illness	40	117	631	762
Mental Illness, Intellectual Disabilities	40,42	0	15	15
Mental Illness, Other Developmental Disabilities	40,43	0	7	7
Intellectual Disabilities	42	0	1	1
Total		117	654	771

Since formation the region continues to experience growth in unduplicated numbers served. This is largely due to development of an Assertive Community Treatment program, crisis services, jail services and providing tele-psych to the member county hospitals to serve all age groups. Adult services have increased from 298 served in FY16 to 654 served in FY18. The number of children receiving tele-psychiatric services through the emergency departments has increased from 5 children to 117 children.

The graph below illustrates the growth in unduplicated service by age group over past three fiscal years.



Total Expenditures by Disability and Chart of Account Type

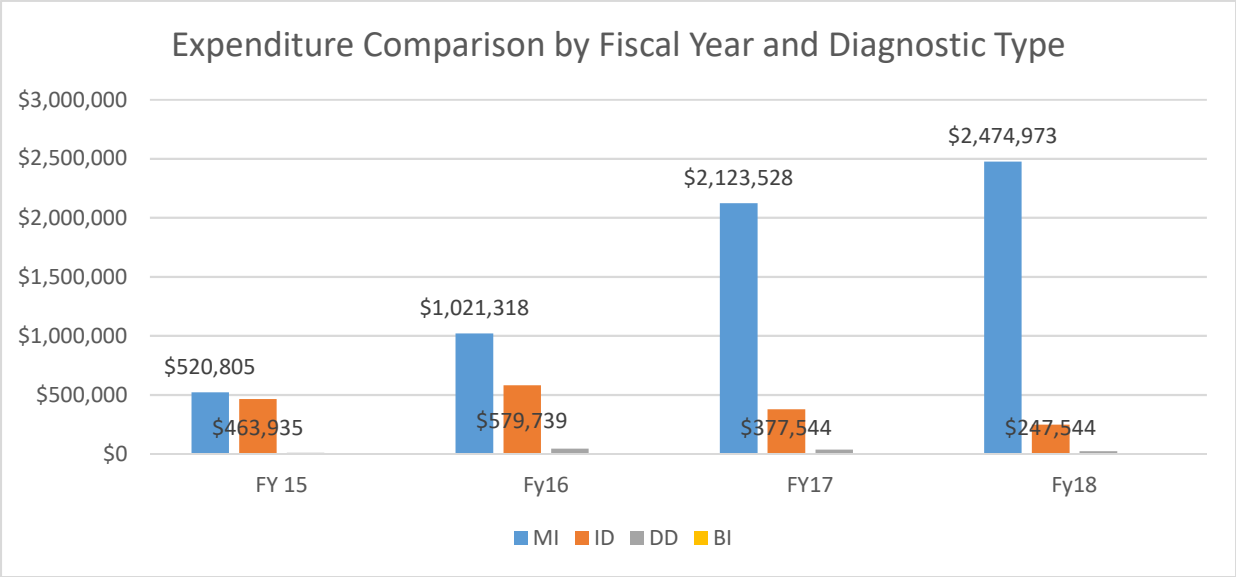
Fiscal Year 2018	County Rural Offices of Social Services MHDS Region	MI (40)	ID (42)	DD (43)	BI (47)	Admin	Other	Total
Core								
	Treatment							
42305	Psychotherapeutic Treatment- Outpatient	$ 700						$ 700.00
42306	Psychotherapeutic Treatment-Medication Prescribing	$ 95.85						$ 95.85
43301	Evaluation (Non-Crisis)-Assessment and Evaluation							
71319	State MHI Inpatient-Per diem charges	$72,915.78						$ 72,915.78
73319	Other Priv./Public Hospitals-Inpatient per diem charges	$ 3,317.25						$ 3,317.25
	Basic Crisis Response							
32322	Support Services-Personal Emergency Response System							
44301	Crisis Evaluation	$ 99,350.00						$ 99,350.00
44305	24 Hour Crisis Response							
	Support for Community Living							
32320	Support services-Home Health Aides	$ 4,436.25						$ 4,436.25
32325	Support Services-Respite Services							
32328	Support Services-Home/Vehicle Modification							
32329	Support Services-Supported Community Living	$ 240,782.43	$ 76,063.20	$ 646.80				$ 317,492..43
	Support for Employment							
50362	Voc./Day-Prevocational Services		$ 2,280.00	$ 1,937.36				$ 4,217.36
50364	Voc./Day-Job Development							
50367	Day Habilitation	$ 6,727.91	$ 5,717.17	$ 5,056.00				$ 17,501.08
50368	Voc./Day-Individual supported Employment			$ 816.00				$ 816.00
50369	Voc./Day-Group Supported Employment							
	Recovery Services							
45323	Peer Family Support – Family Support							
45366	Peer Support-Peer Support Services							
	Service Coordination							
21375	Case Mangement-100% County							
24376	Health Homes Coordination-Coordination Services							
	Core Evidence Based Treatment							
04422	Consultation-Educational and Training Services	$ 17,357.83						$ 17,357.83
32396	Supported Housing		$ 60,669.08					$ 60,669.08
42398	Assertive Community Treatment (ACT)	$ 287,827.20						$ 287,827.20
45373	Peer Family Support- Family Psycho-Education							
	Core Subtotals	$733,510.5	$144,729.45	$8,456.16				$ 886,696.11
Mandated								
46319	Iowa Medical and Classification Center (Oakdale)	$ 16,115.46						$ 16,115.46
72319	State Hospital Schools-Inpatient per diem charges							
74XXX	Commitment Related (except 301)	$ 104,454.54	$ 60.00					$ 104,514.54
75XXX	Mental health advocate							
	Mandated Subtotals:	$145,832.36	$ 60.00					$ 145,892.36

Fiscal Year 2018	County Rural Offices of Social Services MHDS Region	MI (40)	ID (42)	DD (43)	BI (47)	Admin	Other	Total
Core Plus								
	Comprehensive Facility and Community Based Treatment							
44302	23 Hour Observation and Holding							
44307	Mobile Response							
44312	Crisis Stabilization Community Based Services (CSCBS)							
44313	Crisis Stabilization Residential Services (CSRS)	$ 11,600						$ 11,600.00
44346	Crisis Services- Telephone Crisis Service	$ 58,428.00						$ 58,428.00
44366	Warm-Line							
	Sub-Acute Services							
63309	Sub-Acute Services (1-5 Beds)							
64309	Sub-Acute Services (6+Beds)							
	Justice System Involved Services							
25XXX	Coordination Services							
46305	Mental Health Services in Jails	$ 21,842.78						$ 21,842.78
46306	Prescription Medication (Psychiatric Meds in Jail)							
46399	Justice System-Involved Services – Other							
46422	Crisis Prevention training	$ 452.48						$ 452.48
46425	Mental Health Court related expenses							
74301	Civil Commitment Prescreening							
	Additional Core Evidence Based Treatment							
42366	Psychotherapeutic Treatment-Social Support Services							
42397	Psychotherapeutic Treatment-Psychiatric Rehabilitation	$ 1,251.04						$ 1,251.04
	Core Plus Subtotals:	$ 93,574.30						$ 93,574.30
Other Informational Services								
03371	Information and Referral Services							
04372	Planning and /or Consultation Services (Client Related)							
04377	MHDS Contract Provider Incentive Payment							
04399	Consultation							
04429	Planning and Management Consultants (Non-Client related)	$ 12,000.00						$ 12,000.00
05373	Public Education Services	$ 4,097.39						$ 4,097.39
	Other Informational Service Subtotals:	$ 16,097.39						$ 16,097.39

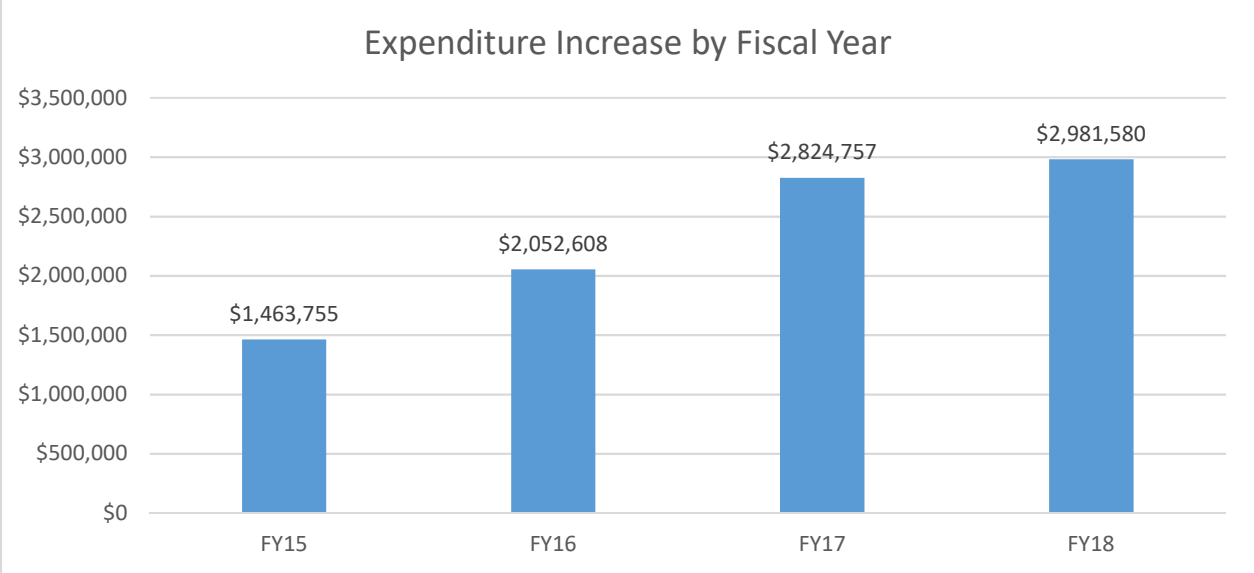
Fiscal Year 2018	County Rural Offices of Social Services MHDS Region	MI (40)	ID (42)	DD (43)	BI (47)	Admin	Other	Total
Community Living Support Services								
06399	Academic Services							
22XXX	Services management	$ 558,834.37	$ 27,229.11					$ 586,063.48
23376	Crisis Care Coordination-Coordination Services	$ 103,475.00						$ 103,475.00
31XXX	Transportation	$ 64,674.69	$ 4,587.00	$ 6,561.00				$ 75,822.69
32321	Support Services – Chore Services							
32326	Support Services-Guardian/Conservator							
32327	Support Services-Representative Payee							
32335	Consumer -Directed Attendant Care							
32399	Support Services -Other							
33330	Mobile Meals							
33340	Basic Needs-Rent Payments	$ 2,756.98						$ 2,756.98
33345	Basic Needs- Ongoing Rent Subsidy	$ 255,712.84						$ 255,712.84
33399	Basic Needs-Other	$ 2,167.25						$ 2,167.25
41305	Physiological Treatment-Outpatient							
41306	Physiological Treatment -Prescription Medicine / Vaccines	$ 1,235.30						$ 1,235.30
41307	Physiological Treatment-In-Home Nursing							
41308	Physiological Treatment-Health Supplies and Equipment							
41399	Physiological Treatment-Other							
42309	Psychotherapeutic Treatment-Partial Hospitalization							
42310	Psychotherapeutic Treatment-Transitional Living Program							
42363	Psychotherapeutic Treatment-Day treatment Services							
42396	Psychotherapeutic Treatment-Comm. Support							
42399	Psychotherapeutic Treatment-Other	$ 24,750.00						$ 24,750.00
44304	Crisis Services-Emergency Care							
50361	Vocational Skills Training							
50365	Supported Education							
50399	Voc./Day-Day Habilitation							
63310	Comm. Based Settings (1-5 Bed)- Assisted Living							
63329	Comm. Based Settings (1-5 Bed)- SCL	$ 12,420.64						$ 12,420.64
63399	Comm. Based Settings (1-5 Bed) - Other							
63XXX	ICF 1-5 Beds							
63XXX	RCF 1-5 Beds	$ 22,582.55						$ 22,582.55
	Community Living Support Services Subtotals:	$ 1,048,609.62	$ 31,816.11	$ 6,561.00				$ 1,086,986.73
Congregate Services								
50360	Voc./Day-Sheltered Workshop Services	$ 35,813.95	$ 45,239.10	$ 6,412.50				$ 87,465.55
64310	Comm. Base Settings (6+ Beds)-Assisted Living							
64329	Comm. Base Settings (6+ Beds)-SCL	$	$ 20,149.22					$ 20,149.22
64399	Comm. Base Settings (6+ Beds)-Other							
64XXX	ICF-6 and over							
64XXX	RCF-6 and over	$ 399,534.67	$ 5,550.00					$ 405,084.67
	Congregate Services Subtotals:	$ 435,348.68	$ 70,938.32	$,412.50				$ 512,699.50

Administration								
11XXX	Direct Administration	$				$227,747.26		$ 227,747.26
12XXX	Purchased Administration					$ 11,936.77		$ 11,936.77
	Administration Subtotals:	$				$ 239,634.03		$ 239,684.03
Uncategorized								
13951	Distribution to MHDS Region Fiscal Agent-Contributions to Other Governments and Org.					$ 1,097,952.00		$ 1,097,952.00
	Uncategorized Subtotals:							
	Regional Totals:	$2,472,973	$247,543.88	$21,429.66		$239,634		$ 2,981,630.42

The following graph depicts the comparison of expenditures by diagnosis over the fiscal years FY15, FY16, FY17, and FY18. The addition of crisis services, I-START, Jail Diversion and Assertive Community Treatment have increased numbers served.



The Chart below depicts the increases in expenditures by fiscal year, comparing FY15, FY16, FY17 and FY18.



REVENUES

FY 2018 Accrual	COUNTY RURAL OFFICES OF SOCIAL SERVICES MHDS Region		
Revenues			
	FY17 Annual Report Ending Fund Balance		$5,453,375
	Adjustments to 6/30/17 Fund Balance		-290,710
	Audited Beginning Fund Balance as of 6/30/17		**$ 5,245,692**
	Local/Regional Funds		$ 2,971,377
10XX	Property Tax Levied	2,930,620	
12XX	Other County Taxes		
16XX	Utility Tax Replacement Excise Taxes		
25XX	Other Governmental Revenues	26,265.8	
4XXX-5XXX	Charges for Services	74.97	
5310	Client Fees		
60XX	Interest		
6XXX	Use of Money & Property		
8XXX	Miscellaneous	14,416.67	
92XX	Proceeds /Gen Fixed assets sales		
	State Funds		**$ -**
21XX	State Tax Credits		
22XX	Other State Replacement Credits		
2250	MHDS Equalization		
24XX	State/Federal pass thru Revenue		
2644	MHDS Allowed Growth // State Gen. Funds		
2645	State Payment Program		
29XX	Payment in Lieu of taxes		
	Federal Funds		**$ -**
2344	Social services block grant		
2345	Medicaid		
	Other		
	Total Revenues		$ 2,971,377.44

Total Funds Available for FY18	$ 8,217,069.44
FY18 Accrual Regional Expenditures	2,981,630.42
Accrual Fund Balance as of 6/30/18	$ 5,235,439.02

Member County Levies

County	2015 Est. Pop.	Regional Per Capita Target	FY18 Max Levy	FY18 Actual Levy	Actual Levy Per Capita
CLARKE	9,259	39.13	362,325	362,325	39.13
DECATUR	8,220	39.13	321,667	321,669	39.13
LUCAS	8,682	39.13	339,746	339,746	39.13
MARION	33,294	39.13	1,302,869	1,089,896	32.74
MONROE	7,973	39.13	312,001	312,001	39.13
RINGGOLD	5,068	39.13	198,322	198,322	39.13
WAYNE	6,385	39.13	249,859	249,859	39.13
Region	**78,881**	39.13	**3,086,789**	**2,873,816**	**39.13**

Outcomes

Service Progress by Core, Additional Core, and EBPs

Core Services continue to be met throughout the region.

Additional Core services implemented in FY 17 were expanded in FY18 along with extensive planning for additional crisis services in response to Senate File 504. An RFP was issued in FY18 for the development of an Access Center incorporating the following services: Screening and Assessment, Mobile Crisis, Peer Support Warm Line and Counseling, Crisis Residential Services, Sub-Acute services, 23 Hour Hold, Sobering Bed and Care Coordination. Many of these additional core services for FY18 will become core services in FY19 due to the 2018 legislative action of House File 2456.

The evidence-based programs established in FY17- Assertive Community Treatment (ACT), Permanent Supported Housing (PSH), and Integrated Co-occurring Disorder Treatment (ICDT), and Mental Health First Aid (MHFA)- were expanded upon in FY18. As part of the CROSS Region 504 plan additional evidence-based programs will be instituted as part of the Access Center which include Illness and Recovery Management, Peer Support and Family Psycho-education.

The Region also initiated some Best Practice Programs in FY18. CROSS, in collaboration with CSS region, initiated the Iowa, Systemic, Therapeutic, Assessment, Resources, & Treatment (I-START) program to provide community-based crisis intervention and prevention service for individuals with intellectual and developmental disabilities (IDD) and mental health needs.

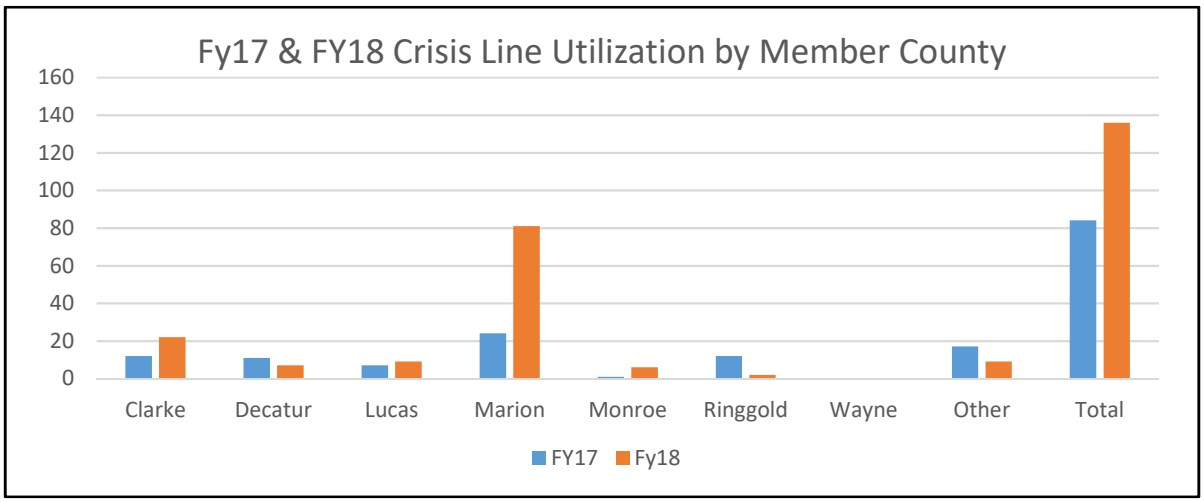
The region also invested in the C3 De-escalation model. This model is directed toward providers, community, law enforcement, schools, families and anyone who touches the life of an individual with complex needs or in mental health crisis.

CRISIS SERVICES

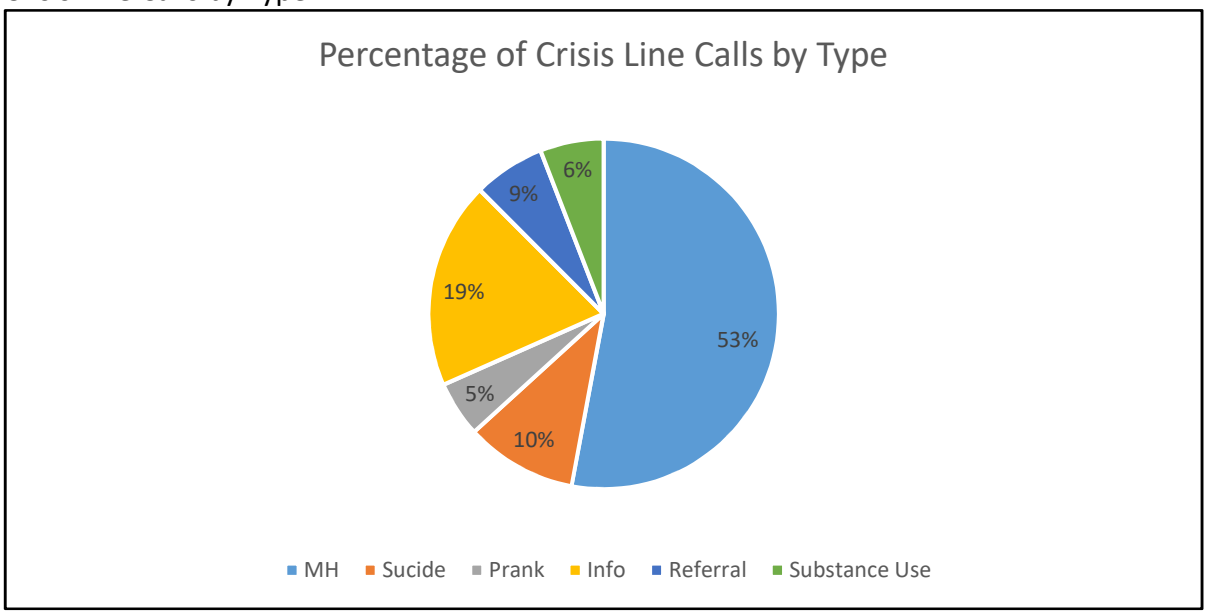
24 Hour crisis hotline

The crisis line was first implemented with Foundation 2 in fiscal year 2017 with a total of 84 calls. The region continues to maintain this 24-hour seven day a week service with an expansion to include Text and Chat access Monday through Friday 8-4. The continued promotion efforts of the crisis line include advertisements and collaboration with other programs such as public health, community health centers, hospitals, schools, law enforcement and pharmacies to include the number on their promotions. Utilization increased slightly in FY18 to a total of 136 calls. Below are charts illustrating the line's utilization and a breakdown of the calls by type. Many of the calls (53%) had a mental health component, 19% were calls looking for information about the crisis line or community services, 10% were suicide intervention, 9% were referrals to services within the region, 6% were for substance use, and the remaining 5% were prank calls which the therapists answering the phone use as an opportunity to educate the caller.

Crisis Line Utilization



Crisis Line Calls by Type



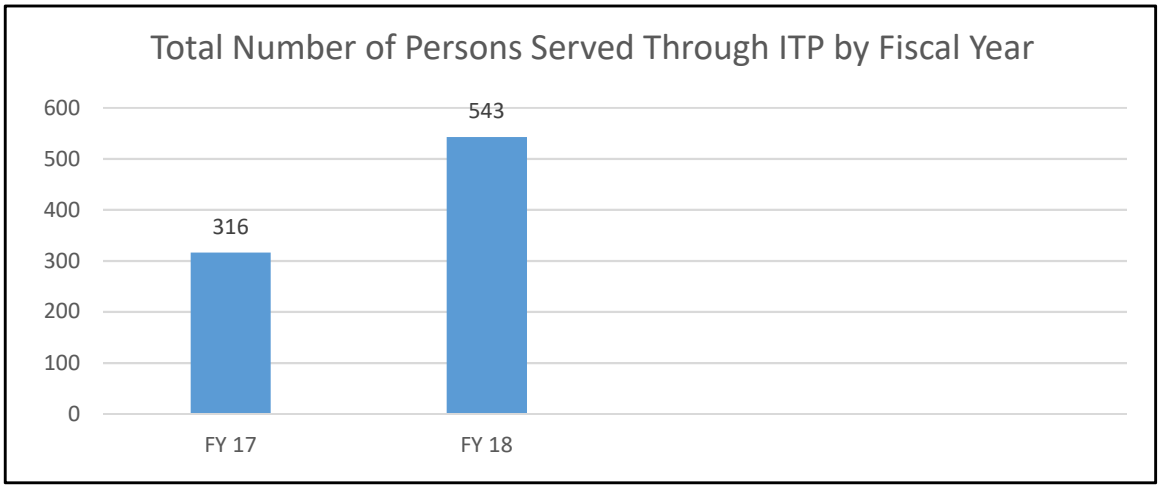
Pre-Commitment Screenings

Pre-Commitment Screening is achieved in varied ways across regions. The CROSS region supports pre-screening using tele-psychiatry purchased for the member county hospitals from Integrated Tele-Health Partners (ITP). Tele-psychiatry is a service that links individuals with a psychiatrist via a two-way connection through the internet. The CROSS region has eight (8) Critical Access Hospitals within the region. While the region has access to Mental Health (MH) hospitals within the 100-mile access requirement, none of the MH hospitals reside within the region. Individuals seeking emergency psychiatric assistance go to the county hospitals for emergent services. This places a strain on our local emergency departments who did not have access to a mental health professional or psychiatrist at most locations, and many physicians do not feel comfortable making the

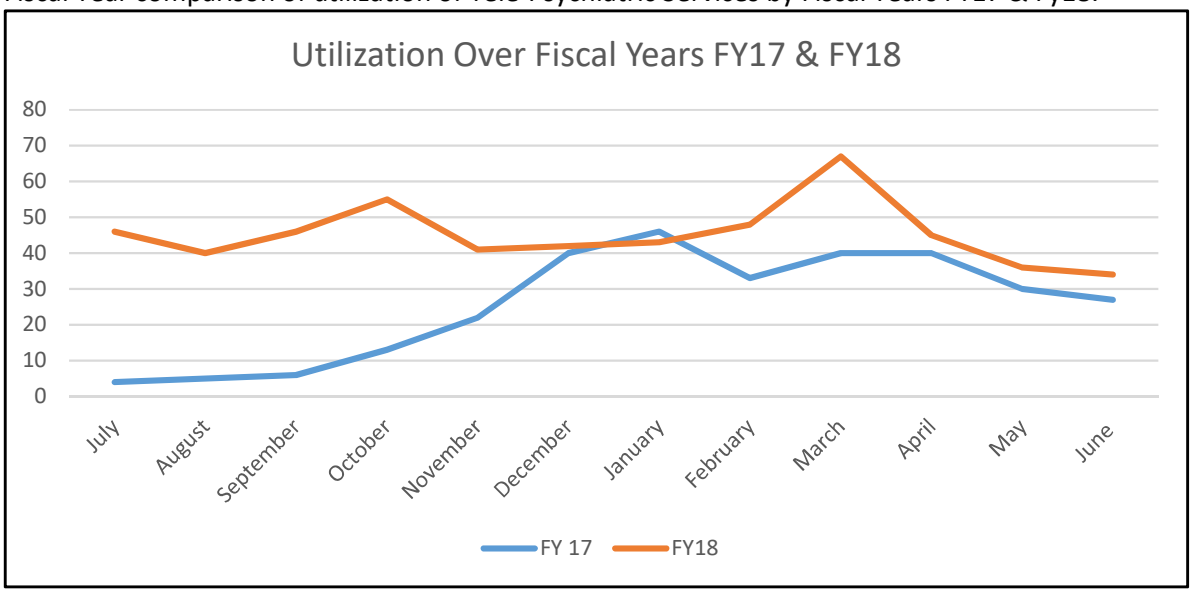
distinction between someone who needs psychiatric in-patient services and someone who needs intensive outpatient services. Tele-psychiatry is one way the region supports our local hospitals to meet this demand.

In addition to having access to a psychiatrist, ITP also provides bed-finding services for the individuals needing inpatient psychiatric services. Our member county hospitals greatly appreciate this service as it relieves emergency department staff from hours of phone calling, so they can focus on patients.

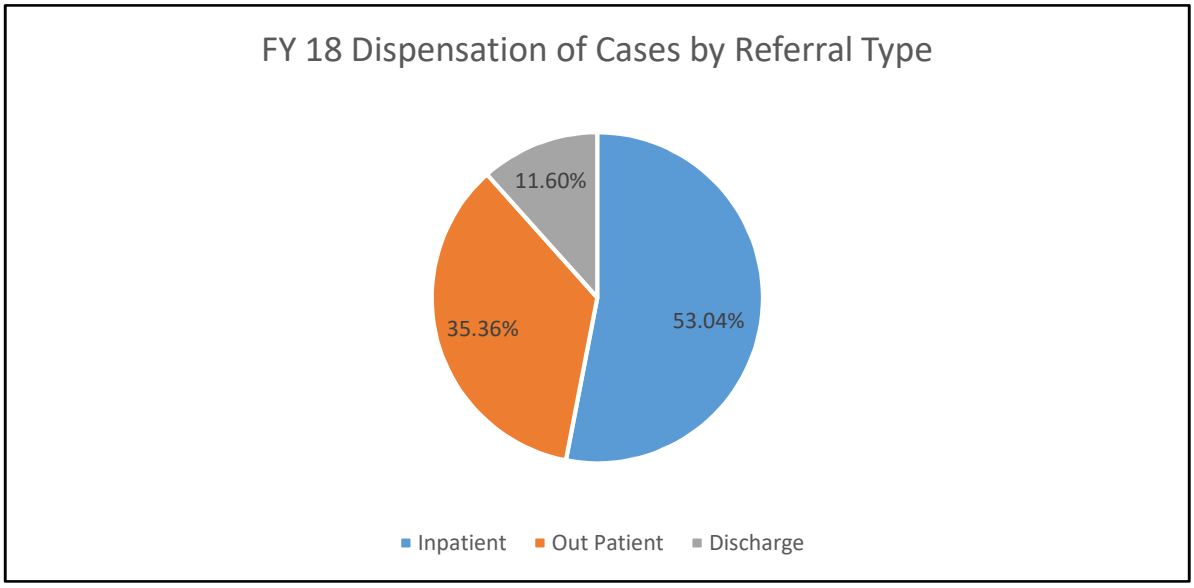
CROSS began tele-psychiatric services in the hospitals at the end of FY16 with full implementation in FY 17. Utilization of the service increased by 237 persons for FY18. This increase is noted in the graphs below.



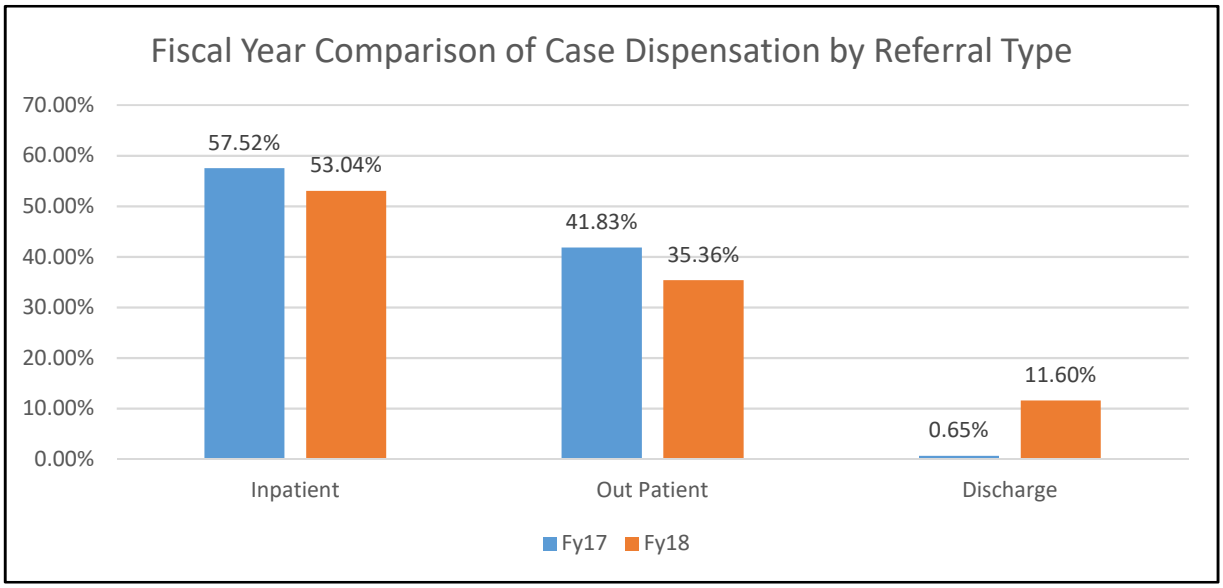
Fiscal Year comparison of utilization of Tele-Psychiatric Services by Fiscal Years FY17 & Fy18.



Of the 543 individuals screened through tele-psych 53.04% were referred on to inpatient psychiatric services, 35.36% were diverted to outpatient services and 11.6% were discharged.



This graph compares the diversion numbers from inpatient psychiatric hospitalization by percentages for fiscal years 2017 and 2018



Crisis Stabilization Residential Services (CSRS) and Non-Committal Transport

The CROSS Region added crisis residential services to the crisis service array in FY 2017 through a contract with Genesis for their program "Hope Wellness" located in the Heart of Iowa Region. CSRS mental health services are voluntary and allow an individual to stabilize and re-integrate back into the community. This service is designed for individuals in need of a safe, secure environment that is less intensive and restrictive than inpatient hospital services. The CROSS region funded ten individuals at Hope Wellness for fiscal year 2018.

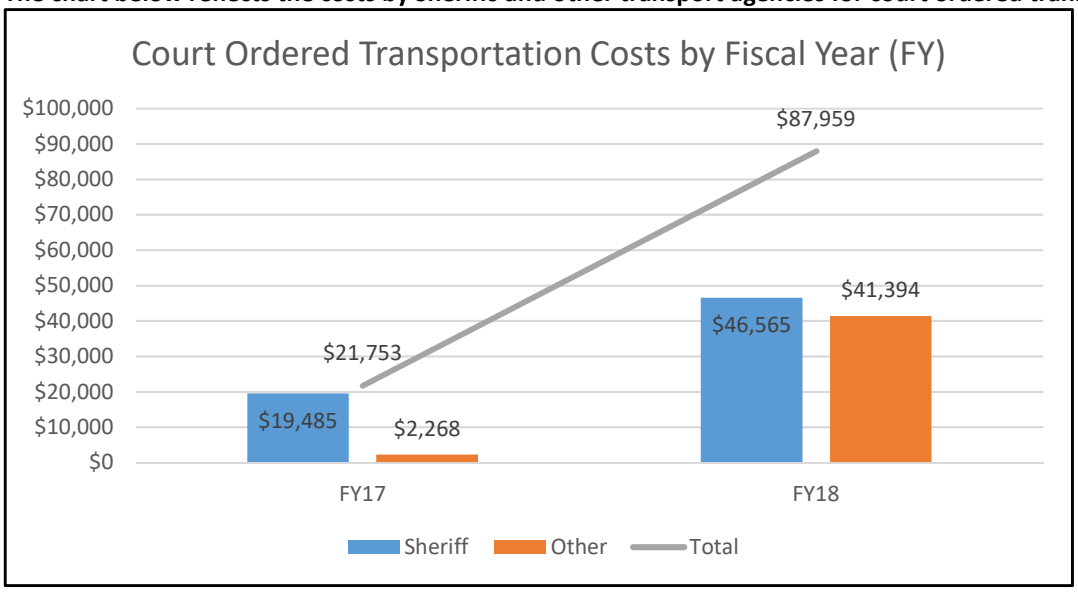
Non-Committal Transport

As previously stated, services at the Crisis Stabilization Residential program are voluntary. Since Hope Wellness is located an average of 68 miles from the CROSS Region the region contracted with Central Iowa Juvenile Detention to provide transportation to and from the program. The region funded trips for eight (8) of the individuals utilizing Hope Wellness.

Mental Health Commitment Transportation

The CROSS region contracted with Central Iowa Juvenile Detention to provide relief transportation for member county Sheriff's Departments to reduce law enforcement time out of the counties at the end of Fiscal Year 2017. In 2017 SF 501 was passed, increasing court ordered, transportation costs from $15.00 per hour to $25.00 per hour. Regions are required to pay for these costs. In fiscal year 2018 the region costs for court ordered, transportation increase by $66,205.99.

The chart below reflects the costs by Sheriffs and other transport agencies for court ordered transport.



Evidence-Based **Practices and Best Practices**

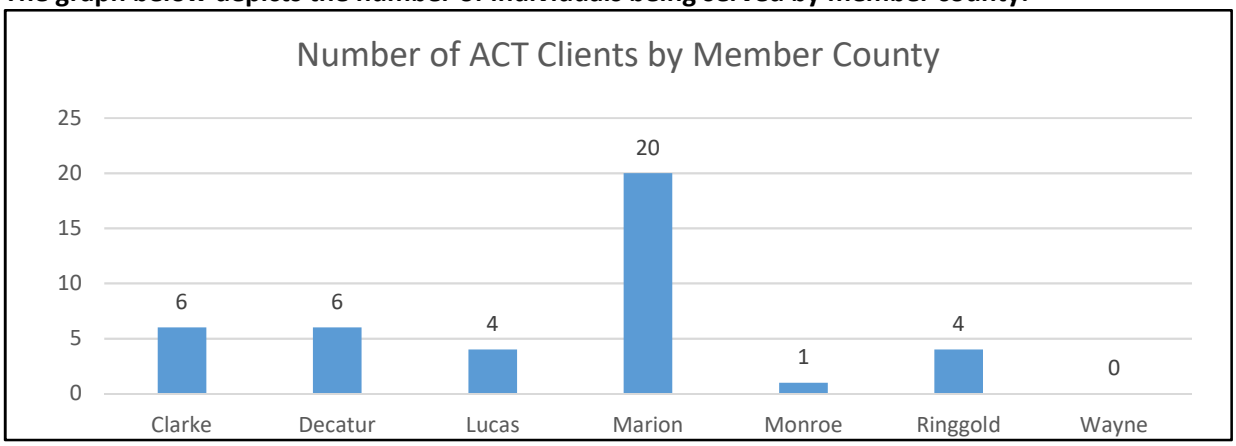
Assertive Community Treatment (ACT)

The CROSS Region began the first rural ACT team in February of 2017. A rural ACT team differs from an urban team in several distinct ways. Rural teams span a large geographical area, have a lower client/staff ratio, and are challenged with finding professional staff. Our team uses technology wherever possible to close these gaps.

ACT was fully funded by a block grant for the first year to allow the service to obtain status as an Iowa Provider and contracts with the MCOs. In year two the team was able to begin billing Medicaid. The region continues with partial funding through a block grant to allow the team to continue to grow their census and reach maximum capacity of 50 individuals. At the end of fiscal year 2018 the team had a census of 41 individuals. The Region's partial funding continues through February 2019.

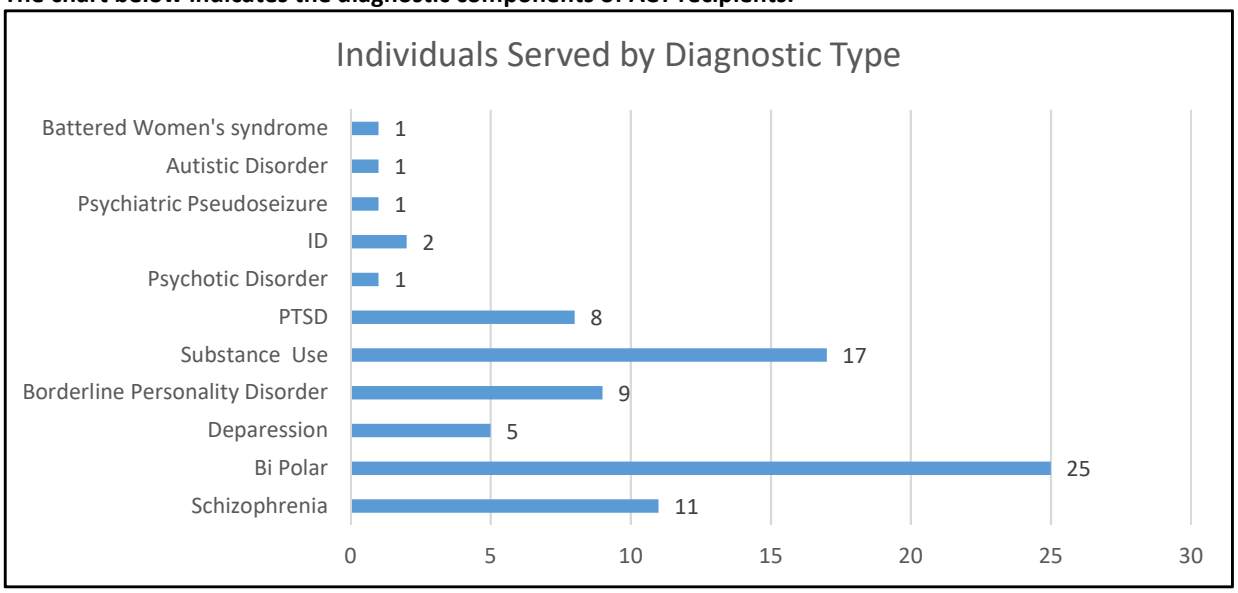
The team is now preparing for a fidelity review to be implemented in FY 2019. Fidelity is a measure of the reliability of the administration of an evidence-based practice. Completion of the fidelity review will also provide the team with valuable information on how to improve outcomes for the individuals being served.

The graph below depicts the number of individuals being served by member county.



The ACT team serves individuals with serious mental illness and at times multiple diagnoses for whom traditional treatment has not been successful.

The chart below indicates the diagnostic components of ACT recipients.



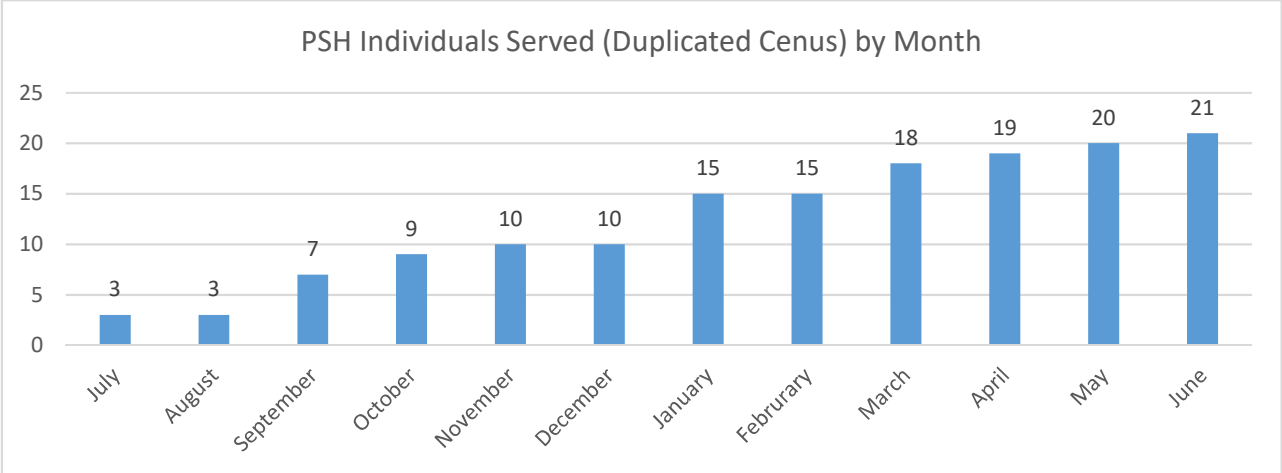
GO TO WWW.RHD.ORG to view one of our success stories and learn how ACT impacts lives.

Permanent Supportive Housing (PSH)

Permanent Supportive Housing (PSH) is a model that combines low-barrier affordable housing, health care, and supportive services to help individuals and families lead more stable lives. PSH typically targets people who are homeless or otherwise unstably housed, experience multiple barriers to housing, and are unable to maintain housing stability without supportive services. This model has been shown to not only impact housing status, but also result in cost savings to various public service systems, including health care.

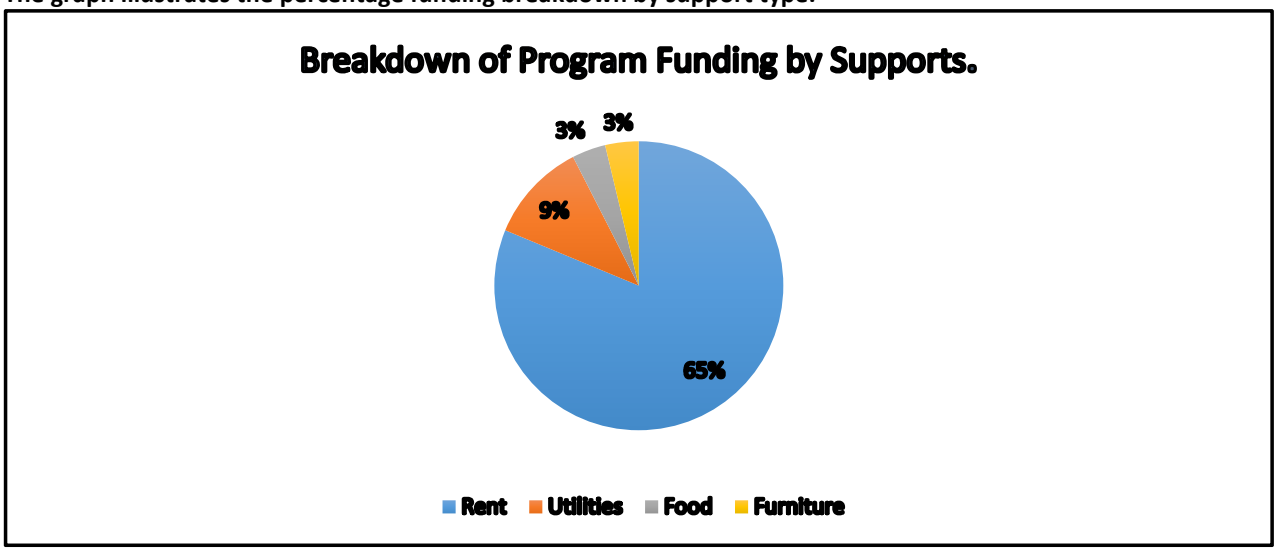
Statistically, individuals with complex needs struggle with homelessness and food insecurity. The Region continues to pair permanent Supportive Housing with the ACT team to provide housing subsidy for individuals in the program who are homeless or do not have enough resources to afford safe housing. A total of 25 individuals with the ACT team were served by this program in FY18.

The graph below illustrates the utilization of the program by month for fiscal year 2018.



The Region spent a total of $79,305 in fiscal year 2018 on the program. The ACT team developed relationships with landlords in the region to obtain integrated housing for participants in the program. The graph below depicts the supports the funding was utilized for in this program.

The graph illustrates the percentage funding breakdown by support type.



Integrated Treatment of Co-Occurring Disorders of Substance Use and Mental Illness (ICODT)

According to the Substance Abuse and Mental Health Administration (SAMHSA), people with mental health disorders are more likely than people without mental health disorders to experience an alcohol or substance use disorder. Co-occurring disorders can be difficult to diagnose due to the complexity of symptoms, as both may vary in severity. In many cases, people receive treatment for one disorder while the other disorder remains untreated. This may occur because both mental and substance use disorders can have biological, psychological, and social components. Other reasons may be inadequate provider training or screening, an overlap of symptoms, or other health issues that need to be addressed first. In any case, the consequences of undiagnosed, untreated, or undertreated co-occurring disorders can lead to a higher likelihood of experiencing homelessness, incarceration, medical illnesses, suicide, or even early death.

People with co-occurring disorders are best served through integrated treatment. With integrated treatment, practitioners can address mental and substance use disorders at the same time, often lowering costs and creating better outcomes. Increasing awareness and building capacity in service systems are important in helping identify and treat co-occurring disorders. Early detection and treatment can improve treatment outcomes and the quality of life for those who need these services.

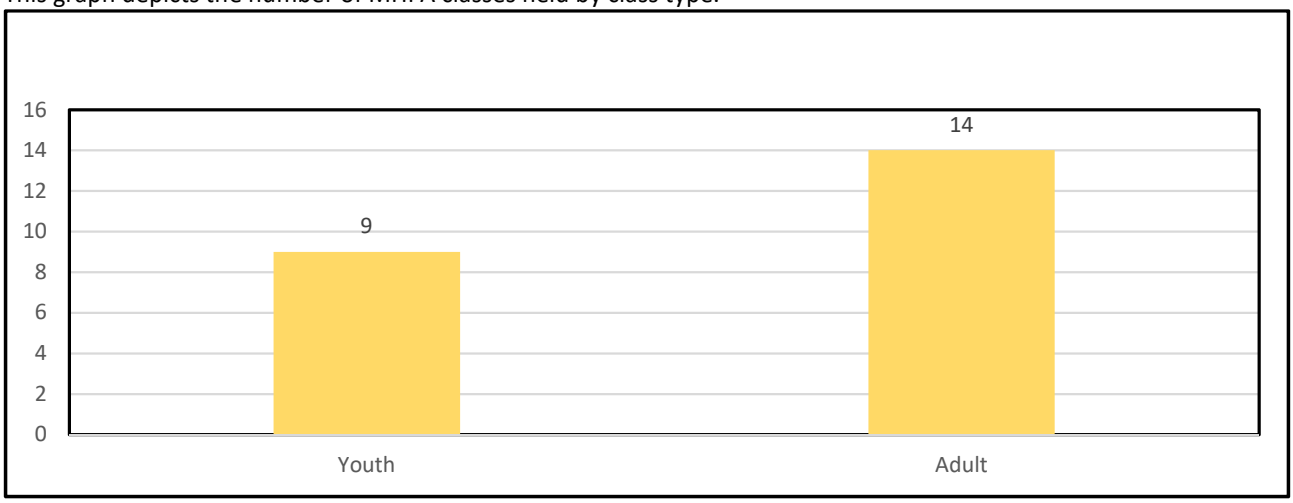
Community Health Centers of Southern Iowa (CHCSI), an FQHC operating in the region, adopted this evidence-based practice for application within the CROSS region. The region supported this initiative through consultation and funding support for the Change company. In FY18 nine staff completed training with the Change Company's nationally approved trainers and began implementing this EBP.

Mental Health First Aide (MHFA)

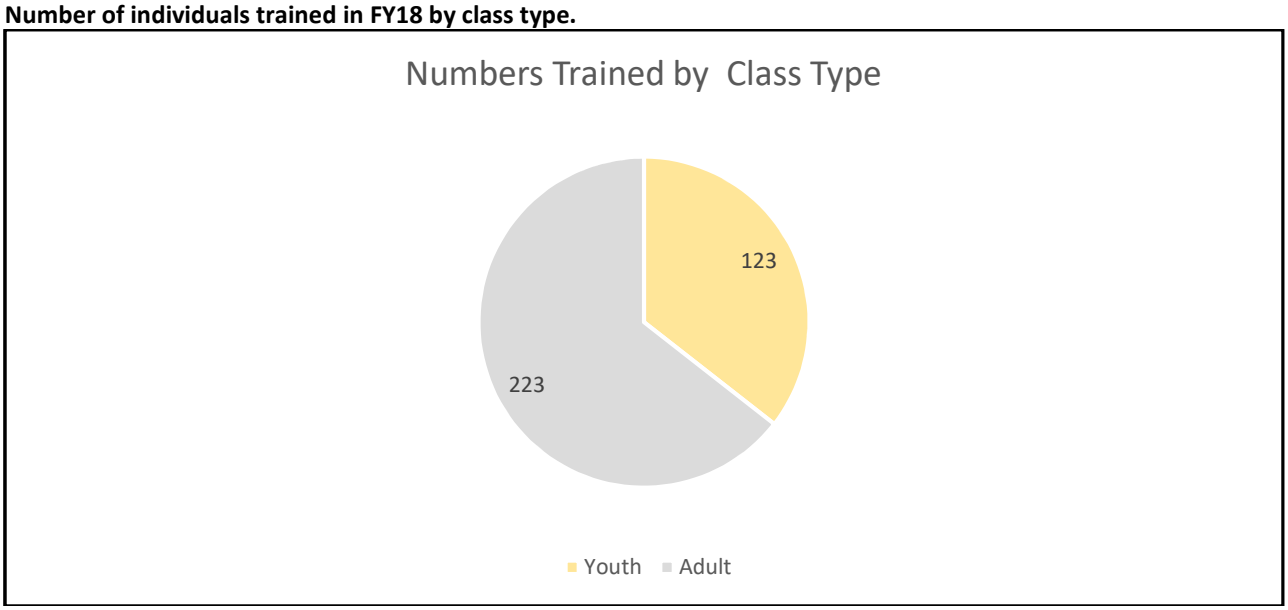
Mental Health First Aid is a course that teaches lay persons how to help someone who is developing a mental health problem or experiencing a mental health crisis. The training helps the lay person to identify, understand, and respond to signs of addictions and mental illnesses.

To increase trainings and expand classes to cover youth and adults the region trained staff in both areas. Twenty-four classes were provided in the region in FY18. MHFA – Youth had nine classes performed and MHFA-Adult-14 classes. A total of 346 individuals were trained. Classes were taught for the general public, law enforcement, schools, colleges, and medical personnel.

This graph depicts the number of MHFA classes held by class type.



Number of individuals trained in FY18 by class type.



Iowa-START (Best Practice and part of the CROSS Region 504 plan)

I-START has been a nationally recognized program model since 1988. I-START (Iowa, Systemic, Therapeutic, Assessment, Resources & Treatment) was started in 1988 by Dr. Joan Beasley and her team to provide community-based crisis intervention and prevention service for individuals with intellectual and developmental disabilities (IDD) and mental health needs. I-START is a comprehensive model of service supports that optimizes independence, treatment, and community living for individuals with IDD and behavioral health needs.

I-START provides prevention and intervention services to individuals with intellectual/developmental disabilities and complex behavioral needs through crisis response, training and consultation. The goal is to create a support network that can respond to crisis needs at the community level. Providing community-based, person-centered supports that enables individuals to remain in their home or community placement is the priority. Working closely with providers, families and the community, I-START provides individualized training to staff, family and community supports working with an individual with complex needs. The one-on-one training and observation are focused around an individualized behavioral and crisis plan. This approach has proven to reduce behaviors, institutional placement, and provider involuntary discharges.

I-START is not currently reimbursable through Medicaid or other funders. This service will receive ongoing funding by the region until other funding mechanisms develop. I-START will directly or indirectly impact all four indicators by increasing staff effectiveness and reducing behaviors that require inpatient treatment or law enforcement involvement.

In Fiscal Year 2018 the CROSS Region collaborated with the CSS Region to initiate the I-START program in the CROSS Region. The I-START team hired a coordinator for the CROSS Region who began undergoing the trainings required for national certification as a case manager in the I-START program. The coordinator completed the training and began to see clients. A total of 6 individuals were admitted to the program in CROSS. (Appendix A has a summary of the I-START FY 18 annual report.)

C3 De-escalation (C3D) (Part of the Region's 504 plan)

C3 De-escalation is a promising practice based on brain research. The C3's represents Calm, Circuit, and Connection. The techniques used in C3 intentionally lower adrenaline production, reduce aggressive behavior (Calm), reconnect the brain to the higher brain functions to regain self-control (Circuit); and assists staff to recognize patterns that lead to aggression to head off a crisis before it begins (Connection). This technique is appropriate for use with people with mental health issues, developmental or intellectual disabilities, substance use disorders, criminal justice involvement, or any combination of the above.

The region added C3 De-escalation to the 504 plans as a resource throughout the region for providers to improve workforce competencies for the complex-need individual. The region trained three Disability Service Coordinators to perform classes and provide follow-up debriefings as class attendees applied the techniques in real life situations. Classes were provided to two providers and one law enforcement group. A total of 38 individuals received training in the first year of implementation.

Jail Services / Law Enforcement – Additional Core

Tele-psych in Jails

The total number of available jail beds in the CROSS Region is 227. The region wanted to respond to the needs of several of our county jails requesting psychiatric care that did not involve transporting inmates. There are six operational jails in the region. Two of the jails already contracted services for tele-psych. The other four jails accepted the offer to have ITP provide tele-psych in their jails. A total of 73 inmates received services through ITP in FY18 which is an increase of 21 individuals compared to the previous fiscal year. Sheriffs have reported fewer concerns of over utilization by inmates, improved communications and reduced barriers to using the service due to ITP system changes.

Jail Re-entry Program and Stepping Up

Stepping Up is the national initiative for counties to reduce the number of individuals with mental illness in jails. The Region has encouraged and collaborated with all member counties to participate in this initiative, and as of September 2017 all seven counties have approved Stepping Up resolutions. The first counties to embrace the initiative came on board in January 2017. Fiscal Year 2018 has been a development year for this initiative.

The re-entry team developed policies and procedures to formalize the Jail Diversion / Re-entry efforts and worked on developing relationships with member county law enforcement. One of the concerns Sheriff's had was the sharing of booking sheet information with the team. The team-initiated phone conferences with the Attorney General's office and member County Attorneys and Sheriffs to discuss their concerns regarding sharing information on booking sheets with the program. These conversations led to the development of an MOU between the member county jails and the region.

The region also assigned a Team Lead for the Jail Diversion program and staff to assist with program implementation in all seven counties. The formalization of the program and the team's efforts has led to member county jails sharing information with the coordinators and increase referrals in fiscal year 2019.

CIT Trainings

The region began offering CIT training to member county Sheriff and Police Departments in fiscal year 2017. The trainings are conducted by the Johnston County Metro Team and provided for free. The region arranges for the classes and pays for the room and board of the attending officers. In FY 2018 the region supported five officers with CIT trainings.

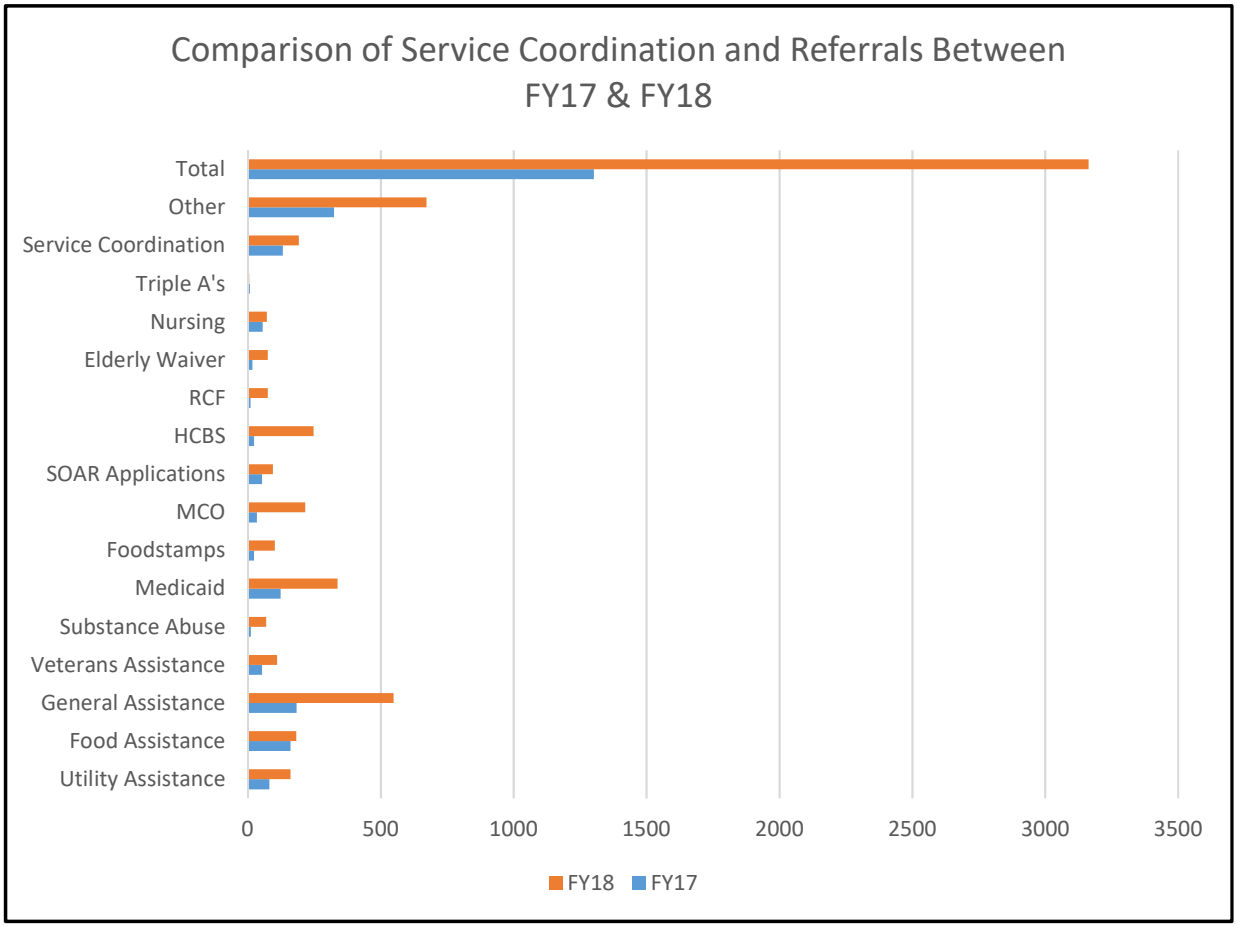
Community Services /Resource and Referral

The Region provides services to our communities that do not appear in standardized reports. One of the critical services we perform is Service Coordination for our member counties. Rural communities no longer have local DHS departments in each county. Many rural residents do not have computers, internet or need assistance in completing applications. The regional offices fill this gap.

Service coordinators in each member county improve access for residents. There were a total of 3,163 resource/referral and service coordination contacts throughout the region. Of the 3,163 referrals 192 had service coordination needs. Referrals came from providers, Integrated Health Homes, Public Health, Hospitals, Churches, law enforcement, prisons, and other regions. Their primary needs included service coordination to determine funding eligibility for group care, Supported Community Living (SCL), transportation, rent subsidy, housing, vocational supports, payee services, benefits issues including Social Security Outreach Access & Recovery (SOAR), connecting to an IHH, and needs assessments.

The 1,972 referrals did not require care coordination but were for resource and referral. The coordinators processed 95 SOAR applications, 338 Medicaid applications, 102 food stamp applications, 548 referrals to general assistance and 161 utility assistance referrals, 110 referrals to Veterans Administration, 183 referrals to the food pantry, 248 referrals to Home and Community Based Providers and 216 referrals to Managed Care Organizations.

The graph below depicts Service Coordination and Resource and Referral Services between FY17 and FY18



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Provider Outcomes – Value Based Contracting

The CROSS Region decided to implement a value-based program system through collaboration with Polk Region and the Law, Health Policy & Disability Center through the University of Iowa College of Law. Together we developed policies and procedures to implement the system while educating providers on the new approach. The following is a key summary of the approach.

The CROSS Region provides financial support and advocates to improve health, hope, and successful outcomes for adults in the region who have mental health, intellectual, or developmental disabilities and recognizes individuals supported may be impacted by multi-occurring issues with other complex human service needs. CROSS strives to create partnerships and a system of care which is welcoming and individual-oriented, person and family driven, recovery/resiliency oriented, trauma-informed, culturally competent, and multi-occurring capable. Community-based services provide opportunities for individuals with disabilities to live balanced and meaningful lives within their community. They promote this mission by developing supportive relationships to work through individuals' life transitions, promoting responsibility through information and options, building opportunities for meaningful community participation, and supporting experiences which create meaningful life roles.

CROSS' charge to the disability system is to reduce and eliminate environmental barriers, make individualized supports readily available, and promote opportunities in all life domains. To this end, the CROSS Region has entered into value-based contracts with four organizations to provide community-based services which support system values. In FY18, the regional system helped 140 participants to remain living in their communities by providing community-based supports and partnering with program participants to create meaningful lives not defined by their disability.

The purpose of the evaluation is to monitor participant and management outcomes and assess the performance of the disability network services. Results are reported and scored for the four participant outcome areas, from 1 "Does Not Meet Minimum Expectations" to 4 "Exceeds Expectations."

FY18 is the first year of the evaluation with targets based on FY17 reported results when available. The system met expectations in three outcome areas (Housing, Employment, and Community Involvement) and was challenged in two outcome areas (Somatic Care and Administrative). Each agency serves a unique blend of individuals and has a specific set of agency specialties. Agencies should aspire to improve their performance. *It is only appropriate to compare each agency's performance across fiscal years instead of comparing all agencies to each other within each fiscal year.*

Of note, the data used to set FY18 targets includes agencies who did not choose to opt into a value-based contract. In October of 2017, agencies who agreed to participate in the value-based contracting process assisted in providing input and setting regional outcome area targets. It is unclear if the shift in participating agencies significantly impacted the region's overall performance rating.

In this first year of the outcome evaluation, FY18 Reported Results reflect participant data reported between April and June of 2018. In order to be scored and incentivized, three criteria were defined. First, a minimum average of 10 participants should be served. Second, agencies had to report data during the fourth quarter of FY18. Third, agencies were asked to monitor data related to jail days,

psychiatric bed days, emergency room usage, and calls for support to law enforcement. Two agencies met all 3 criteria.

The CROSS Region should be proud of their status of being one of the first regions in the State to implement value-based contracting. The citizens of Clarke, Decatur, Lucas, Marion, Monroe, Ringgold, and Wayne counties will benefit by the region's innovativeness and support of local community-based providers.

Region Collaborative – Statewide Outcomes

Statewide Outcomes (Quality Service Development & Assessment, QSDA)

The CROSS Region continues to participate in the Statewide Outcomes project in collaboration with the other regions and CSN to facilitate a standardized approach to the development and delivery of quality MH/DS services measured through the utilization of outcome standards. To review the entire FY18 report see Appendix B.

The region also participates in county associations and committees through ISAC.

Iowa Community Services Association meetings
The ICSA Board represents regional community services in promoting progressive county government administration. The group meets monthly. Kathy Egbert and Tammy Harrah are representatives from CROSS Region.

Legislative Review Committee
The LRC committee reviews current legislation to make recommendations on priorities for legislative action and determine the impact potential legislation may have on the Regional MHDS system. Tammy Harrah is a representative for the CROSS region.

Systems level Collaboration
The CROSS region also collaborated with the CSS region for I-START services, Heart of Iowa Region for residential crisis services, the South Central Behavioral Health region to expand ACT to their region, and the Polk Region for development of value-based contracting system.

Providers
The region encourages local provider collaboration and meets quarterly with a provider stakeholder group made up of providers within the region. All providers are welcome to attend. The group is meant to be a sounding board for the region by communicating with providers on quality improvement projects, evidenced-based practices, and region activities. The group has been focusing on value-based contracting development in addition to training and reporting outcomes supported by the Quality Service Development and Assessment (QSDA) standardized approach.

Last year the region appointed a coordinator to train providers in outcomes reporting and to participate in data validation. Fy18 the region, in conjunction with the value-based

contracting program, performed data validation on provider records for data entered in CSN and the value-based data reported by providers.

The region also tries to be responsive to the training needs of local providers and encourages providers to share trainings. Trainings were provided in C3 De-escalation, MHFA, and evidence-based practices. Providers participated with the I-START team in trainings on medication impact on individuals with intellectual disabilities. Providers also joined the I-START case reviews to participate in analyzing and problem solving for clients with complex needs and behaviors. An exciting outcome of the process was observing providers identifying changes in approaches with direct staff and clients their organizations could implement.

Stakeholders

The CROSS Region supports and encourages stakeholder involvement by having a Regional Advisory Board. The Advisory Board serves as a public forum and assists in the development of regional and strategic plans and their corresponding goals and objectives. In addition to participation in plan development, the Advisory Board provides oversight through monitoring progress toward goals and objectives. The advisory group was crucial in obtaining the I-START program for the region. The advisory group is comprised of 3 involved family members, six providers and is supported by the technical assistance committee.

Other stakeholder groups the region participated in are:

The Marion County Coalition for Change (MC3) meetings 11/20/2017,1/22/2018, 2/26/2018, 3/2/2018, 4/30/2018, 5/29/2018, 6/27/2018. The groups focus is on opioid addiction and prevention. The region provides coordination of the meetings and funding for materials. The meeting is attended by Public Health, Hospitals, Harm Reduction Coalition, Marion County attorney's office, Melcher-Dallas Fire Department, Knoxville School, United Community Services, Pleasantville School and Marion County Sheriff Office, Ministerial Association, and The Well.

Marion County Suicide Prevention group on 11/27/2017, 12/19/2017, 1/25/2018, 3/1/2018, 3/2/2018, 4/10/2018, 4/11/2018, 6/13/20108. The group works on training, resource promotion, community prevention and planning, and response/post planning. The group developed a plan based on the 2015-2018 Iowa Suicide Prevention Plan for Marion County. Attendees are the Knoxville Police Department, Marion County Sheriff, CROSS, Pine Rest, Integrative Counseling Solutions, Knoxville ER, Knoxville School, Knoxville Fire Department/EMS, and Emergency Management. The group conducted a Town Hall Meeting on 1/25/2018 with a power point on suicide prevention and statistics. MHFA classes were offered and performed. Screenagers, a short file depicting the usage of technology directed toward teenagers was shown 3/19/2018.

On 4/26/2018 the region sponsored Bob Vanderpol, MSW with the Pine Rest agency, to present: Lear Skills to Prevent Suicide and Respond Well After Tragic Death at the Your Life Matters: Suicide Prevention Taskforce event. In attendance was the general public, Pastoral Services, Pine Rest, Marion County Public Health, Suicide Awareness Group, Integrative Counseling Solutions and Media.

The region supported Suicide Prevention activities in Ringgold County through the Suicide Awareness Task Force, meeting 1/4/2018, 2/1/2018,4/5/2018,5/3/2018. This group focused

on identifying at risk individuals and following up with referrals, dispersing the 24-hour helpline, and increasing mental health advocacy and awareness of available mental health resources, and removing barriers to their use.

Hospital Coalition meetings are held in Clarke, Decatur, Ringgold, Monroe, and Marion Counties on a monthly or bimonthly basis. The group discusses health care needs in the member county and smoother transitions for individuals utilizing hospital services. The group is composed of providers in the member counties.

Interagency Meetings are held in all member counties and is comprised of community agencies serving member counties to foster community cooperation and collaboration to strengthen families and deliver a complete continuum of services for a healthy citizenship. The participants in the meetings vary by member county but typically the following agencies participate: Community Action Groups, Public Health Departments., Crisis Intervention & Advocacy Center, Graceland University, Development Groups, Family Development & Self-Sufficiency Program, and Parents as Teachers.

The DHS Foster Care Transition Team: 8/4/2017, 9/7/2017, 10/5/2017, 11/2/2017, 12/7/2017, 1/4/2018, 3/1/2018, 4/5/2018, 5/3/2018. The team reviews and gives suggestions to facilitate a successful transition from foster care for youth aging out of the system. Being involved has been crucial during this time of re-organization for both counties and the Medicaid system at large. Keeping this line of communication open has maintained some stability while processes and programs continue to undergo tremendous change and, at times, elimination.

The Region also participates in local ARC meetings on a quarterly basis, Health Fairs put on by local public health departments and hospitals, legislative luncheons, Stepping Up coalition, Rotary, and local hospital community coalition meetings.

Appendix A.

Fiscal Year 2018 Iowa (I)-START Region Annual Report and Program Outcomes

I-START (Systematic, Therapeutic, Assessment, Resources & Treatment) provides prevention and intervention services to adults (17 and older) with intellectual and/or developmental disabilities (IDD) and mental health needs through crisis response, training, consultation, and outreach. I-START uses evidence informed and evidence-based practices to support teams and systems who serve individuals with IDD. I-START's goal is to help individuals remain in their home or community placement. Our role is to support the teams and system to better understand and support the person. Length of enrollment in the program is generally one to two years.

Fiscal Year (FY) 2018 was the third full year of providing I-START (Systematic, Therapeutic, Assessment, Resources & Treatment) services within the County Social Services (CSS) MHDS region. In April 2018 I-START services expanded to the Rolling Hills and CROSS MHDS regions. The Rolling Hills and CROSS regions entered into a written agreement to reimburse CSS for the costs of providing I-START Clinical Services within the respective regions. County Social Services, CROSS, and Rolling Hills offer this service option to teams and systems within the region at no cost. Additionally, the East Central Iowa MHDS Region has expressed an interest in possibly expanding I-START Clinical Services to their region.

In the spring of 2018 a research article titled, "Improving Mental Health Outcomes for Individuals With Intellectual Disability Through the Iowa START (I-START) Program", authored by Joan B. Beasley and Ann Klein, Institute on Disability, University of New Hampshire, Concord, NH; and Luther Kalb Kennedy Krieger Institute, Johns Hopkins Bloomberg School of Public Health, Baltimore, MD was accepted for publication in the JOURNAL OF MENTAL HEALTH RESEARCH IN INTELLECTUAL DISABILITIES. This research was funded through a grant from The Special Hope Foundation.

The research article focused on outcomes from a one-year prospective investigation among 41 individuals with Intellectual Disabilities (ID) and behavioral health needs who received specialized supports from the I-START program (Iowa Systemic, Assessment' Therapeutic, Assessment, Resources and Treatment) operating in a rural region of Iowa. Results indicated that individuals supported by the I-START program experienced significant reductions in mental health symptoms (37% reduction) and had fewer psychiatric emergency department visits (41% reduction) and inpatient psychiatric hospitalizations (54% reduction) over time. Findings highlight that utilization of the START model promotes positive outcomes and improves the lives of people with ID and co-occurring mental health conditions.

I-START Program Outcomes:

In FY 2018, 83 individuals were served through the I-START program. 58% of the referrals were male, 42% female. 42% of the individuals served resided in Supported Living, and 38% resided with their family. There was a significant increase in referrals for individuals who reside with their family in FY 2018. In 2017 only 15% of the enrollees resided in their family home.

Appendix A cont.

70% of I-START Referrals came from Case Managers/IHH Care Coordinators/Services Coordinators, and 21% came from Residential or Day Services Providers. The most common reasons for enrollment in I-START services include aggression, mental health symptoms, risk of place loss, decreased daily functioning, and family needs assistance. 92% of individuals enrolled in I-START reported a psychiatric diagnosis, and 64% reported a medical diagnosis. What the I-START Clinical Team has discovered once accepting a case and providing services, that there were undiagnosed medical problems that resulted in mental health symptoms and problem behaviors. In many cases the undiagnosed medical problems resulted in unnecessary psychiatric diagnoses due to problem behaviors exhibited. Once the medical problems were resolved, there was a significant decrease in mental health symptoms and problem behaviors.

One of the major goals of I-START is to reduce emergency utilization for the individuals we support. Addressing mental health problems in individuals with IDD is critical because, although this population makes up a small percentage of all individuals receiving psychiatric care nationwide, the intensity, complexity, and cost of their care is disproportionately higher. Inpatient care is one step in a continuum of care and should be considered as a last resort given the expense and restrictiveness associated with this setting. Similar to emergency department (ED) visits, unnecessary stays in inpatient psychiatric units represent reactive and restrictive forms of care and can be distressing and traumatic for people with ID and their families. Reducing dependence on the ED and inpatient units, by supporting and promoting access to high-quality community-based care, is a key goal of I-START. FY 2018 data show a 49% reduction in unnecessary psychiatric hospitalization and a 28% reduction in psychiatric emergency department (ED) visits.

Another major goal of the I-START Program is to reduce the frequency and intensity of behavioral and health issues to lead to crisis. Research shows that hyperactivity, irritability, and lethargy are closely correlated with mental health conditions and emergency service use. In fact, mental health symptoms are the principle reason for referral to START and are a primary reason for caregiver stress and decreased family wellbeing. Over time, statistically significant improvements in these subscales have been noted. FY 2018 data show a 26% reduction in mental health symptoms.

I-START Clinical Team planned services are critical supports to teams to better support individuals to prevent unnecessary psychiatric emergency department visits and hospitalizations over time. I-START Coordinators work closely with the team to complete assessments of the individual's strengths and skills, functioning, medical, status, and medications (including side effects). The Coordinator works closely with the team to develop a Cross System Crisis Prevention & Intervention Plan for the individual, which provides the tools needed to support an individual through crisis. Coordinators provide individual or disability specific trainings to teams. Coordinators can conduct onsite observation and staff coaching, as requested by the team. I-START Coordinators complete ongoing outreach with the team. Regular outreach is the most important factor when supporting a team with accomplishing needed goals. Open communication and accountability fostered through regular outreach allows for sustaining positive behavioral change over time. FY 2018 data show that 100% of I-START Planned Services were provided to teams and systems.

Appendix A cont.

I-START provides 24/7 on-call support to teams and systems, including immediate telephonic access for all callers and face-to-face supports in some cases. An essential role of I-START is to provide support and guidance to teams during crisis situations to prevent unnecessary psychiatric emergency room visits or inpatient psychiatric hospitalization. FY 2018 data noted 22 separate individuals with a crisis contact, with a total number of 124 crisis contacts. 85% of the individuals maintained their setting, 7% were admitted to a Crisis Center, 4% were incarcerated or referred to other services, 2% were evaluated at an emergency department, and 2% were admitted for inpatient psychiatric care. The I-START team diverts individuals in crisis to Crisis Centers when appropriate.

In May 2018 a Perception Survey was conducted with teams, systems, and stakeholders on the satisfaction with I-START Clinical Team Services. Survey Monkey was utilized to secure the information from respondents. 100 surveys were emailed out to various stakeholders, with 33 responses received. The responses showed a 91% satisfaction rating for I-START Clinical Services. 48.48% (16) of the respondents were highly satisfied, 42.42% (14) were satisfied, and 9% (3) were slightly dissatisfied. No respondents reported being highly dissatisfied. Additionally, 29 respondents reported being satisfied with overall communication, no respondents reported being dissatisfied with communication.

Appendix B.

QSDA

Quality Service Development, Delivery & Assessment

FY 18 Annual Report

I. QSDA Scope

The Regions have charged QSDA with the following responsibilities:

- Facilitate the implementation of service delivery models- Learning Communities, multi-occurring, culturally capable, evidence based practices, research based practices and trauma informed care.
- Work to ensure that Providers are utilizing Evidence Based Practices, Research Based Practices and Promising Practices.
- Identify and collect Social Determinant Outcome data.
- Work to create a Value Based Service Delivery System utilizing performance/value based contracts.

II. QSDA Mission and Values/Guiding Principles

- **QSDA Mission Statement**: QSDA is a group of stakeholders facilitating a statewide standardized approach to the development and delivery of quality MH/DS services measured through the utilization of outcome standards.
- **QSDA Values/Guiding Principles:**
    - All services should be the best possible.
        - Service Philosophy is based on the 5 Star Quality Model- will always strive to achieve the highest degree of community integration as possible.
        - We have identified the need and value in providing disability support services in the person's home community. We believe individuals with disabilities have the same basic human needs, aspirations, rights, privileges, and responsibilities as other citizens. They should have access to the supports and opportunities available to all persons, as well as to specialized services. Opportunities for growth, improvement, and movement toward independence should be provided in a manner that maintains the dignity and respects the individual needs of each person. Services must be provided in a manner that balances the needs and desires of the consumers against the legal responsibilities and fiscal resources of the Region.
        - We want to support the individual as a citizen, receiving support in the person's home, local businesses, and community of choice, where the array of disability services are defined by the person's unique needs, skills and talents. Where decisions are made through personal circles of support, with

        - the desired outcome a high quality of life achieved by self-determined relationships.
        - We envision a wide array of community living services designed to move individuals beyond their clinically diagnosed disability. Individuals supported by community living services should have community presence (characterized by blending community integration, community participation, and community relationships).
        - Through the use of Evidence Based Practices, (EBP) and Research Based Practices, (RBP), Regions will continually strive to improve service quality.
    - Activities must be meaningful.
        - Any task or work completed must be meaningful which helps ensure Agency empowerment and the efficient use of staff time.
    - Will ensure the use of standardized/efficient practices.
        - Work to establish a single data entry process.
        - Will work to ensure that outcome measures align.
        - Coordinated training process.
    - QSDA structure, projects and processes shall be based on a philosophy of accommodation and flexibility.
    - Utilize website to organize resource information, data, activities, training and process tracks.
    - QSDA will actively work to collect social determinant data and utilize it to help transition the service delivery system to a value based model.

III. Strategic Action Plan

The following projects define the FY 18 Strategic Action Plan. The FY 18 Plan in addition to identifying new tasks is also a continuation and expansion of a number of FY 17 projects that will also then continue into FY 19. Projects are grouped within four Strategic Areas: Service Development, Service Delivery, Service Assessment/Outcomes and System Infrastructure.

- **Service Development**
    - Urban Rural Learning Community Development
        - Facilitate development of Learning Communities for legislated EBPs, including TI/COD/CC with service delivery team.
        - Coordinate with ISCA Training Committee on state-wide trainings involving QSDA initiatives.
        - Support collaboration among CEOs and Regions to address mutual interests where possible.
        - Work on collaboration with the statewide QSDA Service Assessment team for mutually beneficial services.
    - Develop a Statewide Trauma Informed Care trainer network.
        - Develop a TI Training Network with the Lincoln NE model to support a unified, consistent and sustainable TI training model statewide.
        - Identify costs and funders for this model.
        - Work collaboratively with CEOs and Providers to support this model in Regions.
    - Develop an Integrated Co-Occurring Practice Model
        - Coordinate efforts with CEOs, ITAIC, DHS and IDPH.
        - Develop a state-wide training in cooperation with the Service Delivery Team
        - Populate the QSDA website with Integrated Co-Occurring Care resources.
    - Work with seven Regions to pilot the C3, (De-escalation) process which includes training the trainers.

- Continue QSDA Website development of Service Environment information.
  - Continue to develop tool kit/resource directory for Trauma Informed Care.
  - Develop tool kit/resource directory for Integrated Co-Occurring Disorders.
  - Develop tool kit/resource directory for Cultural Competency.

- **Service Delivery Work Group**
  - Support utilization of Evidence Based Practices, Research Based Practices, Best Practices and Promising Practices.
    - Support and participate in a multi-region Employment EBP.
    - Coordinate training and supports, including in house expertise for Supported Employment, Permanent Supportive Housing and Co-Occurring Disorders.
    - Provide C3 De-escalation training for direct support staff and Providers.
  - Measure effectiveness of Evidence Based Practices, Research Based Practices, Best Practices and Promising Practices, including but not limited to: Supported Employment, Permanent Supportive Housing and Co-Occurring.
    - Emphasis through training and supports on Outcomes-positive results with individuals.
    - Assist Agencies in determination of fidelity.
  - Develop a statewide EBP Provider list and populate QSDA website.

- **Service Assessment Work Group**
  - Provide Outcomes training.
    - Provide Outcome Project Overview training
    - Train Regional Staff to perform data reviews
    - Train Regional Staff and Providers to utilize data to set goals.
  - Generate Outcome reports from CSN and validate accuracy.
    - Survey Providers and CEOs to establish report content
    - Develop Provider report procedure manual
    - Generate Regional reports
    - Generate a statewide reports
    - Generate Provider reports
  - Implement Phase II, Data Review
    - Train Regional staff
    - Perform Provider data reviews
  - Implement Phase III, Setting Annual goals and Develop Incentives
    - Create Agency summary from 12 month data review.
    - Establish Outcome targets and goals for next 12 months.
    - Create Provider supports to maintain and improve performance.
    - Work with the CROSS region to develop Phase III.

- **System Infrastructure**
  - Website – Populate Work Group data and resource information
    - Transition to new software base.
    - Expand Functionality
    - Create training listing
    - Populate Work Group info.
  - Initiate and Coordinate training
    - Work with the Community Services Training Committee, IACP, MCOs, and DHS to develop training tracks.
    - Coordinate train the trainer functions.

- Participate in planning and developing Value Based Service Delivery system.

IV. FY 18 Achievements

- Maintained member participation.
  - QSDA has membership participation from the Regions, Providers, MCOs and DHS.
  - Expanded membership for the Service Assessment/Outcomes work group to include those Regional individuals that are doing reviews and those Providers who have participated in a review.
- Increased participation in the Outcomes Project
  - Currently outcomes are being entered by 80 Providers.
  - Completed 15 Agency reviews.
  - Began working on a draft of Phase III, Goals, Targets and Supports**.**
  - Provided training on the Outcomes Project
  - The CROSS region working with the Polk County Region, added 5 additional measures, and moved into Phase III. Additionally they created an incentive fund and contracted with the Univ. of Ia. to develop an independent evaluation which provided the foundation for incentive distribution.
- Maintained and enhanced the CSN Provider Portal.
  - CSN created a Provider Committee. This Committee scoped the CSN Provider/Outcome enhancements. CSN staff finished coding, testing and implemented by July 1, 2018.
- Training Process – Worked with the Iowa Community Services Affiliate, Regions and the Iowa Association of Community Providers to coordinate and fund training within the QSDA scope.
- Continued working with a multi-regional consortium looking at EBPs for supported housing and employment.
- Training
  - Trainings were conducted on Evidence Based Practices, 5 star quality, value based contracting and Trauma Informed Care.
- Met regularly with Regional CEOs providing updates and recommendations.
- Worked with Regional CEOs, Providers and MCO representatives in the formation of an Outcomes and Training Committee. This Committee is responsible for coordinating outcome creation, outcome data collection, identifying training needs and facilitating training opportunities.
- The Service Development & Delivery workgroups, worked with the following Regions: Polk, CICS, NW Iowa Care Connection, CROSS, South East Iowa Link, South Central Behavioral Health and Southwest Iowa MHDS to establish a C3, (Calm-Circuit-Connection) De-escalation pilot project.
- Worked with IACP, MCOs and IME to establish a standardized Employment outcome reporting period.
- A Consultant, hired by the CICS and South Central Behavioral Health regions, has looked at national research and presented an overview of value based purchasing.
- Five QSDA Executive Committee members attended the Open Minds Conference on Value Based Service Delivery.
- Have been working with CSN staff to begin identifying ways to share information, collect and manage data.
- QSDA facilitated a meeting with Simply Connect, a company that offers a way to access and manage health information. One of their projects is in Minnesota, where all 87 counties/Providers are connected so that Care Teams can share information and generate alerts.
- Reprogrammed the QSDA website so that it can now be populated with project and program information.